

AMENDED IN ASSEMBLY APRIL 16, 2013

AMENDED IN ASSEMBLY MARCH 19, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL

No. 18

Introduced by Assembly Member Pan

December 3, 2012

An act to amend ~~Section~~ *Sections 1367.003, 1367.005, and 1385.02* of, *and to add Section 1367.013 to*, the Health and Safety Code, and to amend ~~Section~~ *Sections 10112.25, 10112.27, and 10181.2* of, *and to add Section 10112.35 to*, the Insurance Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 18, as amended, Pan. ~~Individual health~~ *Health care coverage*; *coverage: pediatric oral care*.

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires a health insurance issuer that offers coverage in the small group or individual market to ensure that such coverage, with respect to plan years on or after January 1, 2014, includes the essential health benefits package, which is defined to include pediatric oral care benefits. PPACA requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, as specified, and requires an exchange to allow an issuer to offer stand-alone dental plans in the exchange, provided that the plans cover the pediatric oral care benefits required under the essential health benefits package.

Existing law establishes the California Health Benefit Exchange (Exchange) to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and qualified small employers by January 1, 2014. Existing law requires carriers participating in the Exchange that sell products outside the Exchange to offer, market, and sell all products made available to individuals and small employers through the Exchange to individuals and small employers purchasing coverage outside the Exchange. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits and defines those benefits to include the pediatric oral care benefits ~~covered~~ *provided* under a specified dental plan available to subscribers of the Healthy Families Program.

This bill would exempt a plan contract or policy offered through the Exchange from covering those pediatric oral care benefits if the Exchange offers a stand-alone dental plan as described in PPACA and would require stand-alone dental plans offered through the Exchange to include coverage of those pediatric oral care benefits. *The bill would also require cost sharing that is imposed as a result of a specialized health care service plan contract or policy that covers pediatric oral care benefits to be coordinated with the cost sharing associated with a qualified health plan that is offered, marketed, or sold through the Exchange. The bill would also prohibit those specialized plan contracts or policies from being regarded as providing excepted benefits, as specified.*

Existing law requires a health care service plan and a health insurer to comply with minimum medical loss ratios and to provide an annual rebate to each insured if the medical loss ratio is less than a certain percentage, as specified.

This bill would require a specialized health care service plan contract and specialized health insurance policy that provides pediatric oral care benefits through the Exchange to also comply with minimum medical loss ratios and provide an annual rebate, as specified.

Existing law requires the Department of Managed Health Care and the Department of Insurance to promulgate regulations applicable to

health care service plans and specified health insurers, respectively, to ensure that enrollees and insureds have the opportunity to access needed health care services in a timely manner, and to ensure adequacy of numbers of professional providers and institutional providers. Existing law requires health care service plans and health insurance policies to file specified rate information with the Department of Managed Health Care and the Department of Insurance, respectively, at least 60 days before implementing a rate change.

This bill would specify that those provisions would also apply to specialized health care service plans and specialized health insurance policies that provide pediatric oral care benefits through the Exchange. Because a willful violation of the bill's provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: $\frac{2}{3}$. Appropriation: no. Fiscal committee: yes.

State-mandated local program: ~~no~~-yes.

The people of the State of California do enact as follows:

1 **SECTION 1.** *Section 1367.003 of the Health and Safety Code*
2 *is amended to read:*
3 1367.003. (a) Every health care service plan that issues, sells,
4 renews, or offers health care service plan contracts for health care
5 coverage in this state, including a grandfathered health plan, but
6 not including specialized health care service plan contracts, shall
7 provide an annual rebate to each enrollee under such coverage, on
8 a pro rata basis, if the ratio of the amount of premium revenue
9 expended by the health care service plan on the costs for
10 reimbursement for clinical services provided to enrollees under
11 such coverage and for activities that improve health care quality
12 to the total amount of premium revenue, excluding federal and
13 state taxes and licensing or regulatory fees and after accounting

1 for payments or receipts for risk adjustment, risk corridors, and
2 reinsurance, is less than the following:

3 (1) With respect to a health care service plan offering coverage
4 in the large group market, 85 percent.

5 (2) With respect to a health care service plan offering coverage
6 in the small group market or in the individual market, 80 percent.

7 (b) Every health care service plan that issues, sells, renews, or
8 offers health care service plan contracts for health care coverage
9 in this state, including a grandfathered health plan, shall comply
10 with the following minimum medical loss ratios:

11 (1) With respect to a health care service plan offering coverage
12 in the large group market, 85 percent.

13 (2) With respect to a health care service plan offering coverage
14 in the small group market or in the individual market, 80 percent.

15 (c) *Every specialized health care service plan contract described*
16 *in Section 1311(d)(2)(B)(ii) of PPACA, as defined in Section*
17 *1367.005, (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) providing pediatric*
18 *oral care benefits in the small group or individual market through*
19 *the Exchange, shall provide an annual rebate to each enrollee*
20 *under that coverage, on a pro rata basis, if the ratio of the amount*
21 *of premium revenue expended by the specialized health care service*
22 *plan on the costs for reimbursement for services provided to*
23 *enrollees under that coverage and for activities that improve dental*
24 *care quality to the total amount of premium revenue, excluding*
25 *federal and state taxes and licensing or regulatory fees and after*
26 *accounting for payments or receipts for risk adjustment, risk*
27 *corridors, and reinsurance, is less than 75 percent.*

28 (d) *Every specialized health care service plan contract described*
29 *in subdivision (c) shall maintain a minimum medical loss ratio of*
30 *75 percent.*

31 ~~(e)~~

32 (e) (1) The total amount of an annual rebate required under ~~this~~
33 ~~section~~ *subdivision (a)* shall be calculated in an amount equal to
34 the product of the following:

35 (A) The amount by which the percentage described in paragraph
36 (1) or (2) of subdivision (a) exceeds the ratio described in paragraph
37 (1) or (2) of subdivision (a).

38 (B) The total amount of premium revenue, excluding federal
39 and state taxes and licensing or regulatory fees and after accounting

1 for payments or receipts for risk adjustment, risk corridors, and
2 reinsurance.

3 (2) A health care service plan shall provide any rebate owing
4 to an enrollee no later than August 1 of the calendar year following
5 the year for which the ratio described in subdivision (a) was
6 calculated.

7 ~~(d)~~

8 (f) (1) The director may adopt regulations in accordance with
9 the Administrative Procedure Act (Chapter 3.5 (commencing with
10 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
11 Code) that are necessary to implement the medical loss ratio as
12 described under Section 2718 of the federal Public Health Service
13 Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations
14 issued under that section.

15 (2) The director may also adopt emergency regulations in
16 accordance with the Administrative Procedure Act (Chapter 3.5
17 (commencing with Section 11340) of Part 1 of Division 3 of Title
18 2 of the Government Code) when it is necessary to implement the
19 applicable provisions of this section and to address specific
20 conflicts between state and federal law that prevent implementation
21 of federal law and guidance pursuant to Section 2718 of the federal
22 Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial
23 adoption of the emergency regulations shall be deemed to be an
24 emergency and necessary for the immediate preservation of the
25 public peace, health, safety, or general welfare.

26 ~~(e)~~

27 (g) The department shall consult with the Department of
28 Insurance in adopting necessary regulations, and in taking any
29 other action for the purpose of implementing this section.

30 ~~(f)~~

31 (h) This section shall be implemented to the extent required by
32 federal law and shall comply with, and not exceed, the scope of
33 Section 2791 of the federal Public Health Service Act (42 U.S.C.
34 Sec. 300gg-91) and the requirements of Section 2718 of the federal
35 Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules
36 or regulations issued under those sections.

37 ~~(g)~~

38 (i) Nothing in this section shall be construed to apply to
39 provisions of this chapter pertaining to financial statements, assets,

1 liabilities, and other accounting items to which subdivision (s) of
2 Section 1345 applies.

3 ~~(h)~~

4 (j) Nothing in this section shall be construed to apply to a health
5 care service plan contract or insurance policy issued, sold, renewed,
6 or offered for health care services or coverage provided in the
7 Medi-Cal program (Chapter 7 (commencing with Section 14000)
8 of Part 3 of Division 9 of the Welfare and Institutions Code), the
9 Healthy Families Program (Part 6.2 (commencing with Section
10 12693) of Division 2 of the Insurance Code), the Access for Infants
11 and Mothers Program (Part 6.3 (commencing with Section 12695)
12 of Division 2 of the Insurance Code), the California Major Risk
13 Medical Insurance Program (Part 6.5 (commencing with Section
14 12700) of Division 2 of the Insurance Code), or the Federal
15 Temporary High Risk Insurance Pool (Part 6.6 (commencing with
16 Section 12739.5) of Division 2 of the Insurance Code), to the extent
17 consistent with the federal Patient Protection and Affordable Care
18 Act (Public Law 111-148).

19 ~~SECTION 1.~~

20 SEC. 2. Section 1367.005 of the Health and Safety Code is
21 amended to read:

22 1367.005. (a) An individual or small group health care service
23 plan contract issued, amended, or renewed on or after January 1,
24 2014, shall, at a minimum, include coverage for essential health
25 benefits pursuant to PPACA and as outlined in this section. For
26 purposes of this section, “essential health benefits” means all of
27 the following:

28 (1) Health benefits within the categories identified in Section
29 1302(b) of PPACA: ambulatory patient services, emergency
30 services, hospitalization, maternity and newborn care, mental health
31 and substance use disorder services, including behavioral health
32 treatment, prescription drugs, rehabilitative and habilitative services
33 and devices, laboratory services, preventive and wellness services
34 and chronic disease management, and pediatric services, including
35 oral and vision care.

36 (2) (A) The health benefits covered by the Kaiser Foundation
37 Health Plan Small Group HMO 30 plan (federal health product
38 identification number 40513CA035) as this plan was offered during
39 the first quarter of 2012, as follows, regardless of whether the

benefits are specifically referenced in the evidence of coverage or plan contract for that plan:

(i) Medically necessary basic health care services, as defined in subdivision (b) of Section 1345 and in Section 1300.67 of Title 28 of the California Code of Regulations.

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha feto protein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

(iii) Any other benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in those statutes.

(iv) The health benefits covered by the plan that are not otherwise required to be covered under this chapter, to the extent required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the California Code of Regulations.

(v) Any other health benefits covered by the plan that are not otherwise required to be covered under this chapter.

(B) Where there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements

1 for health benefits under this chapter that were enacted prior to
2 December 31, 2011, the requirements of this chapter shall be
3 controlling, except as otherwise specified in this section.

4 (C) Notwithstanding subparagraph (B) or any other provision
5 of this section, the home health services benefits covered under
6 the plan identified in subparagraph (A) shall be deemed to not be
7 in conflict with this chapter.

8 (D) For purposes of this section, the Paul Wellstone and Pete
9 Domenici Mental Health Parity and Addiction Equity Act of 2008
10 (Public Law 110-343) shall apply to a contract subject to this
11 section. Coverage of mental health and substance use disorder
12 services pursuant to this paragraph, along with any scope and
13 duration limits imposed on the benefits, shall be in compliance
14 with the Paul Wellstone and Pete Domenici Mental Health Parity
15 and Addiction Equity Act of 2008 (Public Law 110-343), and all
16 rules, regulations, or guidance issued pursuant to Section 2726 of
17 the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

18 (3) With respect to habilitative services, in addition to any
19 habilitative services identified in paragraph (2), coverage shall
20 also be provided as required by federal rules, regulations, and
21 guidance issued pursuant to Section 1302(b) of PPACA.
22 Habilitative services shall be covered under the same terms and
23 conditions applied to rehabilitative services under the plan contract.

24 (4) With respect to pediatric vision care, the same health benefits
25 for pediatric vision care covered under the Federal Employees
26 Dental and Vision Insurance Program vision plan with the largest
27 national enrollment as of the first quarter of 2012. The pediatric
28 vision care benefits covered pursuant to this paragraph shall be in
29 addition to, and shall not replace, any vision services covered under
30 the plan identified in paragraph (2).

31 (5) (A) With respect to pediatric oral care, the same health
32 benefits for pediatric oral care covered under the dental plan
33 available to subscribers of the Healthy Families Program in
34 2011–12, including the provision of medically necessary
35 orthodontic care provided pursuant to the federal Children’s Health
36 Insurance Program Reauthorization Act of 2009. This subparagraph
37 shall not apply to a health care service plan contract ~~offered that~~
38 *is a qualified health plan, as defined in Section 100501 of the*
39 *Government Code, that is offered, marketed, or sold* through the
40 Exchange if a specialized health care service plan contract

1 described in ~~Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec.~~
2 ~~18031(d)(2)(B)(ii))~~ subdivision (c) is offered, marketed, or sold
3 through the Exchange. *Notwithstanding subdivision (f) of Section*
4 *100503 of the Government Code, a qualified health plan that*
5 *excludes coverage of the benefits described in Section*
6 *1311(d)(2)(B)(ii) of PPACA shall not be offered, marketed, or sold*
7 *outside of the Exchange.*

8 (B) The pediatric oral care benefits covered pursuant to this
9 paragraph shall be in addition to, and shall not replace, any dental
10 or orthodontic services covered under the plan identified in
11 paragraph (2).

12 (C) *Cost sharing that is imposed as a result of a specialized*
13 *health care service plan contract described in subdivision (c) shall*
14 *be coordinated with that cost sharing which is associated with the*
15 *qualified health plan identified in subparagraph (A), so that the*
16 *total cost sharing for a combined qualified health plan and*
17 *specialized health care service plan pursuant to this paragraph*
18 *does not exceed the total cost sharing for a qualified health plan*
19 *that includes coverage of the benefits described in Section*
20 *1311(d)(2)(B)(ii) of the PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)).*
21 *The plans shall develop a method for coordinating and tracking*
22 *cost sharing that limits the burden on the subscriber.*

23 (b) Subdivision (a) shall not apply to any of the following:

24 (1) A specialized health care service plan contract.

25 (2) A Medicare supplement plan contract.

26 (3) A plan contract that qualifies as a grandfathered health plan
27 under Section 1251 of PPACA or any rules, regulations, or
28 guidance issued pursuant to that section.

29 (c) (1) A specialized health care service plan contract described
30 in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec.
31 18031(d)(2)(B)(ii)) that is offered through the Exchange shall, at
32 a minimum, include coverage of the health benefits described in
33 subparagraph (A) of paragraph (5) of subdivision (a).

34 (2) *A specialized health care service plan contract described*
35 *in paragraph (1) shall not be regarded as providing excepted*
36 *benefits under either the Public Health Service Act or PPACA, for*
37 *the purpose of determining the applicability of Sections 2701 to*
38 *2706, inclusive, and Sections 2708 and 2711 of the Public Health*
39 *Service Act, added by Section 1201 of PPACA, relating to the*
40 *following:*

1 (A) *The prohibition of preexisting condition exclusions or other*
2 *discrimination based on health status.*

3 (B) *Fair health insurance premiums.*

4 (C) *Guaranteed availability of coverage.*

5 (D) *Guaranteed renewability of coverage.*

6 (E) *Prohibition against discrimination against individual*
7 *participants and beneficiaries on the basis of health status.*

8 (F) *Nondiscrimination in health care.*

9 (G) *Prohibition of excessive waiting periods, annual limits, and*
10 *lifetime limits.*

11 (d) *Pediatric vision and oral care benefits described in*
12 *paragraphs (4) and (5) of subdivision (a) shall be provided for*
13 *individuals up to 26 years of age, to the extent permitted under*
14 *PPACA. Treatment limitations imposed on health benefits*
15 *described in this section shall be no greater than the treatment*
16 *limitations imposed by the corresponding plans identified in*
17 *subdivision (a), subject to the requirements set forth in paragraph*
18 *(2) of subdivision (a).*

19 (e) Except as provided in subdivision (f), nothing in this section
20 shall be construed to permit a health care service plan to make
21 substitutions for the benefits required to be covered under this
22 section, regardless of whether those substitutions are actuarially
23 equivalent.

24 (f) To the extent permitted under Section 1302 of PPACA and
25 any rules, regulations, or guidance issued pursuant to that section,
26 and to the extent that substitution would not create an obligation
27 for the state to defray costs for any individual, a plan may substitute
28 its prescription drug formulary for the formulary provided under
29 the plan identified in subdivision (a) as long as the coverage for
30 prescription drugs complies with the sections referenced in clauses
31 (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision
32 (a) that apply to prescription drugs.

33 (g) No health care service plan, or its agent, solicitor, or
34 representative, shall issue, deliver, renew, offer, market, represent,
35 or sell any product, contract, or discount arrangement as compliant
36 with the essential health benefits requirement in federal law, unless
37 it includes coverage of the health benefits described in subdivision
38 (a), including the benefits described in subparagraph (A) of
39 paragraph (5) of subdivision (a), and meets the requirements of
40 subdivisions (d), (e), and (f).

1 (h) Except as otherwise provided in this section, this section
2 shall apply regardless of whether the plan contract is offered inside
3 or outside the Exchange.

4 (i) Nothing in this section shall be construed to exempt a plan
5 or a plan contract from meeting other applicable requirements of
6 law.

7 (j) This section shall not be construed to prohibit a plan contract
8 from covering additional benefits, including, but not limited to,
9 spiritual care services that are tax deductible under Section 213 of
10 the Internal Revenue Code.

11 (k) Nothing in this section shall be implemented in a manner
12 that conflicts with a requirement of PPACA.

13 (l) This section shall be implemented only to the extent essential
14 health benefits are required pursuant to PPACA.

15 (m) An essential health benefit is required to be provided under
16 this section only to the extent that federal law does not require the
17 state to defray the costs of the benefit.

18 (n) Nothing in this section shall obligate the state to incur costs
19 for the coverage of benefits that are not essential health benefits
20 as defined in this section.

21 (o) A plan is not required to cover, under this section, changes
22 to health benefits that are the result of statutes enacted on or after
23 December 31, 2011.

24 (p) (1) The department may adopt emergency regulations
25 implementing this section. The department may, on a one-time
26 basis, readopt any emergency regulation authorized by this section
27 that is the same as, or substantially equivalent to, an emergency
28 regulation previously adopted under this section.

29 (2) The initial adoption of emergency regulations implementing
30 this section and the readoption of emergency regulations authorized
31 by this subdivision shall be deemed an emergency and necessary
32 for the immediate preservation of the public peace, health, safety,
33 or general welfare. The initial emergency regulations and the
34 readoption of emergency regulations authorized by this section
35 shall be submitted to the Office of Administrative Law for filing
36 with the Secretary of State and each shall remain in effect for no
37 more than 180 days, by which time final regulations may be
38 adopted.

1 (3) The director shall consult with the Insurance Commissioner
2 to ensure consistency and uniformity in the development of
3 regulations under this subdivision.

4 (4) This subdivision shall become inoperative on March 1, 2016.

5 (q) For purposes of this section, the following definitions shall
6 apply:

7 (1) "Exchange" means the California Health Benefit Exchange
8 created by Section 100500 of the Government Code.

9 (2) "Habilitative services" means medically necessary health
10 care services and health care devices that assist an individual in
11 partially or fully acquiring or improving skills and functioning and
12 that are necessary to address a health condition, to the maximum
13 extent practical. These services address the skills and abilities
14 needed for functioning in interaction with an individual's
15 environment. Examples of health care services that are not
16 habilitative services include, but are not limited to, respite care,
17 day care, recreational care, residential treatment, social services,
18 custodial care, or education services of any kind, including, but
19 not limited to, vocational training. Habilitative services shall be
20 covered under the same terms and conditions applied to
21 rehabilitative services under the plan contract.

22 (3) (A) "Health benefits," unless otherwise required to be
23 defined pursuant to federal rules, regulations, or guidance issued
24 pursuant to Section 1302(b) of PPACA, means health care items
25 or services for the diagnosis, cure, mitigation, treatment, or
26 prevention of illness, injury, disease, or a health condition,
27 including a behavioral health condition.

28 (B) "Health benefits" does not mean any cost-sharing
29 requirements such as copayments, coinsurance, or deductibles.

30 (4) "PPACA" means the federal Patient Protection and
31 Affordable Care Act (Public Law 111-148), as amended by the
32 federal Health Care and Education Reconciliation Act of 2010
33 (Public Law 111-152), and any rules, regulations, or guidance
34 issued thereunder.

35 (5) "Small group health care service plan contract" means a
36 group health care service plan contract issued to a small employer,
37 as defined in Section 1357.500.

38 *SEC. 3. Section 1367.013 is added to the Health and Safety*
39 *Code, to read:*

1 1367.013. *A specialized health care service plan contract*
2 *described in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec.*
3 *18031(d)(2)(B)(ii)) that provides pediatric oral care benefits*
4 *through the Exchange shall be subject to Sections 1367, 1367.03,*
5 *and 1342, and Article 6.2 (commencing with Section 1385.01).*

6 SEC. 4. *Section 1385.02 of the Health and Safety Code is*
7 *amended to read:*

8 1385.02. This article shall apply to health care service plan
9 contracts offered in the individual or group market in California.
10 However, this article shall not apply to a specialized health care
11 service plan contract, *other than one providing pediatric oral care*
12 *benefits through the Exchange, as described in Section 1367.013;*
13 a Medicare supplement contract subject to Article 3.5 (commencing
14 with Section 1358.1); a health care service plan contract offered
15 in the Medi-Cal program (Chapter 7 (commencing with Section
16 14000) of Part 3 of Division 9 of the Welfare and Institutions
17 Code); a health care service plan contract offered in the Healthy
18 Families Program (Part 6.2 (commencing with Section 12693) of
19 Division 2 of the Insurance Code), the Access for Infants and
20 Mothers Program (Part 6.3 (commencing with Section 12695) of
21 Division 2 of the Insurance Code), the California Major Risk
22 Medical Insurance Program (Part 6.5 (commencing with Section
23 12700) of Division 2 of the Insurance Code), or the Federal
24 Temporary High Risk Pool (Part 6.6 (commencing with Section
25 12739.5) of Division 2 of the Insurance Code); a health care service
26 plan conversion contract offered pursuant to Section 1373.6; or a
27 health care service plan contract offered to a federally eligible
28 defined individual under Article 4.6 (commencing with Section
29 1366.35) or Article 10.5 (commencing with Section 1399.801).

30 SEC. 5. *Section 10112.25 of the Insurance Code is amended*
31 *to read:*

32 10112.25. (a) Every health insurer that issues, sells, renews,
33 or offers health insurance policies for health care coverage in this
34 state, including a grandfathered health plan, but not including
35 specialized health insurance policies, shall provide an annual rebate
36 to each insured under such coverage, on a pro rata basis, if the
37 ratio of the amount of premium revenue expended by the health
38 insurer on the costs for reimbursement for clinical services
39 provided to insureds under such coverage and for activities that
40 improve health care quality to the total amount of premium

1 revenue, excluding federal and state taxes and licensing or
2 regulatory fees and after accounting for payments or receipts for
3 risk adjustment, risk corridors, and reinsurance, is less than the
4 following:

5 (1) With respect to a health insurer offering coverage in the
6 large group market, 85 percent.

7 (2) With respect to a health insurer offering coverage in the
8 small group market or in the individual market, 80 percent.

9 (b) Every health insurer that issues, sells, renews, or offers health
10 insurance policies for health care coverage in this state, including
11 a grandfathered health plan, shall comply with the following
12 minimum medical loss ratios:

13 (1) With respect to a health insurer offering coverage in the
14 large group market, 85 percent.

15 (2) With respect to a health insurer offering coverage in the
16 small group market or in the individual market, 80 percent.

17 (c) *Every specialized health insurance policy described in*
18 *Section 1311(d)(2)(B)(ii) of PPACA, as defined in Section*
19 *10112.27, (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) providing pediatric*
20 *oral care benefits in the small group or individual market through*
21 *the Exchange, shall provide an annual rebate to each insured*
22 *under that coverage, on a pro rata basis, if the ratio of the amount*
23 *of premium revenue expended by the health insurer on the costs*
24 *for reimbursement for services provided to insureds under that*
25 *coverage and for activities that improve dental care quality to the*
26 *total amount of premium revenue, excluding federal and state taxes*
27 *and licensing or regulatory fees and after accounting for payments*
28 *or receipts for risk adjustment, risk corridors, and reinsurance, is*
29 *less than 75 percent.*

30 (d) *Every specialized health insurance policy described in*
31 *subdivision (c) shall maintain a minimum medical loss ratio of 75*
32 *percent.*

33 (e)

34 (e) (1) The total amount of an annual rebate required under ~~this~~
35 ~~section~~ *subdivision (a)* shall be calculated in an amount equal to
36 the product of the following:

37 (A) The amount by which the percentage described in paragraph
38 (1) or (2) of subdivision (a) exceeds the ratio described in paragraph
39 (1) or (2) of subdivision (a).

1 (B) The total amount of premium revenue, excluding federal
2 and state taxes and licensing or regulatory fees and after accounting
3 for payments or receipts for risk adjustment, risk corridors, and
4 reinsurance.

5 (2) A health insurer shall provide any rebate owing to an insured
6 no later than August 1 of the calendar year following the year for
7 which the ratio described in subdivision (a) was calculated.

8 ~~(d)~~

9 ~~(f)~~ (1) The commissioner may adopt regulations in accordance
10 with the Administrative Procedure Act (Chapter 3.5 (commencing
11 with Section 11340) of Part 1 of Division 3 of Title 2 of the
12 Government Code) that are necessary to implement the medical
13 loss ratio as described under Section 2718 of the federal Public
14 Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal
15 rules or regulations issued under that section.

16 (2) The commissioner may also adopt emergency regulations
17 in accordance with the Administrative Procedure Act (Chapter 3.5
18 (commencing with Section 11340) of Part 1 of Division 3 of Title
19 2 of the Government Code) when it is necessary to implement the
20 applicable provisions of this section and to address specific
21 conflicts between state and federal law that prevent implementation
22 of federal law and guidance pursuant to Section 2718 of the federal
23 Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial
24 adoption of the emergency regulations shall be deemed to be an
25 emergency and necessary for the immediate preservation of the
26 public peace, health, safety, or general welfare.

27 ~~(e)~~

28 (g) The department shall consult with the Department of
29 Managed Health Care in adopting necessary regulations, and in
30 taking any other action for the purpose of implementing this
31 section.

32 ~~(f)~~

33 (h) This section shall be implemented to the extent required by
34 federal law and shall comply with, and not exceed, the scope of
35 Section 2791 of the federal Public Health Service Act (42 U.S.C.
36 Sec. 300gg-91) and the requirements of Section 2718 of the federal
37 Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules
38 or regulations issued under those sections.

39 ~~(g)~~

(i) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5)), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

~~SEC. 2.~~

SEC. 6. Section 10112.27 of the Insurance Code is amended to read:

10112.27. (a) An individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2014, shall, at a minimum, include coverage for essential health benefits pursuant to PPACA and as outlined in this section. This section shall exclusively govern what benefits a health insurer must cover as essential health benefits. For purposes of this section, “essential health benefits” means all of the following:

(1) Health benefits within the categories identified in Section 1302(b) of PPACA: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

(2) (A) The health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2012, as follows, regardless of whether the benefits are specifically referenced in the plan contract or evidence of coverage for that plan:

(i) Medically necessary basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code

1 and in Section 1300.67 of Title 28 of the California Code of
2 Regulations.

3 (ii) The health benefits mandated to be covered by the plan
4 pursuant to statutes enacted before December 31, 2011, as
5 described in the following sections of the Health and Safety Code:
6 Sections 1367.002, 1367.06, and 1367.35 (preventive services for
7 children); Section 1367.25 (prescription drug coverage for
8 contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46
9 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha
10 fetoprotein testing); Section 1367.6 (breast cancer screening);
11 Section 1367.61 (prosthetics for laryngectomy); Section 1367.62
12 (maternity hospital stay); Section 1367.63 (reconstructive surgery);
13 Section 1367.635 (mastectomies); Section 1367.64 (prostate
14 cancer); Section 1367.65 (mammography); Section 1367.66
15 (cervical cancer); Section 1367.665 (cancer screening tests);
16 Section 1367.67 (osteoporosis); Section 1367.68 (surgical
17 procedures for jaw bones); Section 1367.71 (anesthesia for dental);
18 Section 1367.9 (conditions attributable to diethylstilbestrol);
19 Section 1368.2 (hospice care); Section 1370.6 (cancer clinical
20 trials); Section 1371.5 (emergency response ambulance or
21 ambulance transport services); subdivision (b) of Section 1373
22 (sterilization operations or procedures); Section 1373.4 (inpatient
23 hospital and ambulatory maternity); Section 1374.56
24 (phenylketonuria); Section 1374.17 (organ transplants for HIV);
25 Section 1374.72 (mental health parity); and Section 1374.73
26 (autism/behavioral health treatment).

27 (iii) Any other health benefits mandated to be covered by the
28 plan pursuant to statutes enacted before December 31, 2011, as
29 described in those statutes.

30 (iv) The health benefits covered by the plan that are not
31 otherwise required to be covered under Chapter 2.2 (commencing
32 with Section 1340) of Division 2 of the Health and Safety Code,
33 to the extent otherwise required pursuant to Sections 1367.18,
34 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health
35 and Safety Code, and Section 1300.67.24 of Title 28 of the
36 California Code of Regulations.

37 (v) Any other health benefits covered by the plan that are not
38 otherwise required to be covered under Chapter 2.2 (commencing
39 with Section 1340) of Division 2 of the Health and Safety Code.

(B) Where there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements for health benefits under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code that were enacted prior to December 31, 2011, the requirements of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code shall be controlling, except as otherwise specified in this section.

(C) Notwithstanding subparagraph (B) or any other provision of this section, the home health services benefits covered under the plan identified in subparagraph (A) shall be deemed to not be in conflict with Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) shall apply to a policy subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(3) With respect to habilitative services, in addition to any habilitative services identified in paragraph (2), coverage shall also be provided as required by federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(4) With respect to pediatric vision care, the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2012. The pediatric vision care services covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (2).

(5) (A) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental plan available to subscribers of the Healthy Families Program in 2011–12, including the provision of medically necessary

orthodontic care provided pursuant to the federal Children’s Health Insurance Program Reauthorization Act of 2009. This subparagraph shall not apply to a health insurance policy ~~offered that is a qualified health plan, as defined in Section 100501 of the Government Code, that is offered, marketed, or sold~~ through the Exchange if a specialized health insurance policy described in ~~Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii))~~ subdivision (c) is offered, marketed, or sold through the Exchange. *Notwithstanding subdivision (f) of Section 100503 of the Government Code, a qualified health plan that excludes coverage of the benefits described in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) shall not be offered, marketed, or sold outside of the Exchange.*

(B) The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).

(C) *Cost sharing that is imposed as a result of a specialized health insurance policy described in subdivision (c) shall be coordinated with that cost sharing which is associated with the qualified health plan identified in subparagraph (A), so that the total cost sharing for a combined qualified health plan and specialized health insurance policy pursuant to this paragraph does not exceed the total cost sharing for a qualified health plan that includes coverage of the benefits described in Section 1311(d)(2)(B)(ii) of PPACA. The insurer and qualified health plan shall develop a method for coordinating and tracking cost-sharing that limits the burden on the policyholder.*

(b) Subdivision (a) shall not apply to any of the following:

(1) A policy that provides excepted benefits as described in Sections 2722 and 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

(2) A policy that qualifies as a grandfathered health plan under Section 1251 of PPACA or any binding rules, ~~regulation,~~ *regulations*, or guidance issued pursuant to that section.

(c) (1) A specialized health insurance policy described in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) that is offered through the Exchange shall, at a minimum, include coverage of the health benefits described in subparagraph (A) of paragraph (5) of subdivision (a).

(2) A specialized health insurance policy described in paragraph (1) providing pediatric oral care benefits shall not be regarded as providing excepted benefits under either the Public Health Service Act or PPACA, for the purpose of determining the applicability of Sections 2701 to 2706, inclusive, and Sections 2708 and 2711 of the Public Health Service Act, added by Section 1201 of PPACA, relating to the following:

(A) The prohibition of preexisting condition exclusions or other discrimination based on health status.

(B) Fair health insurance premiums.

(C) Guaranteed availability of coverage.

(D) Guaranteed renewability of coverage.

(E) Prohibition against discrimination against individual participants and beneficiaries on the basis of health status.

(F) Nondiscrimination in health care.

(G) Prohibition of excessive waiting periods, annual limits, and lifetime limits.

(d) Pediatric vision and oral care benefits described in paragraphs (4) and (5) of subdivision (a) shall be provided for individuals up to 26 years of age, to the extent permitted under PPACA. Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).

(e) Except as provided in subdivision (f), nothing in this section shall be construed to permit a health insurer to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.

(f) To the extent permitted under Section 1302 of PPACA and any rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, an insurer may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) as long as the coverage for prescription drugs complies with the sections referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision (a) that apply to prescription drugs.

(g) No health insurer, or its agent, producer, or representative, shall issue, deliver, renew, offer, market, represent, or sell any

1 product, policy, or discount arrangement as compliant with the
2 essential health benefits requirement in federal law, unless it
3 includes coverage of the health benefits described in subdivision
4 (a), including the benefits described in subparagraph (A) of
5 paragraph (5) of subdivision (a), and meets the requirements of
6 subdivisions (d), (e), and (f). This subdivision shall be enforced
7 in the same manner as Section 790.03, including through the means
8 specified in Sections 790.035 and 790.05.

9 (h) Except as otherwise provided in this section, this section
10 shall apply regardless of whether the policy is offered inside or
11 outside the Exchange.

12 (i) Nothing in this section shall be construed to exempt a health
13 insurer or a health insurance policy from meeting other applicable
14 requirements of law.

15 (j) This section shall not be construed to prohibit a policy from
16 covering additional benefits, including, but not limited to, spiritual
17 care services that are tax deductible under Section 213 of the
18 Internal Revenue Code.

19 (k) Nothing in this section shall be implemented in a manner
20 that conflicts with a requirement of PPACA.

21 (l) This section shall be implemented only to the extent essential
22 health benefits are required pursuant to PPACA.

23 (m) An essential health benefit is required to be provided under
24 this section only to the extent that federal law does not require the
25 state to defray the costs of the benefit.

26 (n) Nothing in this section shall obligate the state to incur costs
27 for the coverage of benefits that are not essential health benefits
28 as defined in this section.

29 (o) An insurer is not required to cover, under this section,
30 changes to health benefits that are the result of statutes enacted on
31 or after December 31, 2011.

32 (p) (1) The commissioner may adopt emergency regulations
33 implementing this section. The commissioner may, on a one-time
34 basis, readopt any emergency regulation authorized by this section
35 that is the same as, or substantially equivalent to, an emergency
36 regulation previously adopted under this section.

37 (2) The initial adoption of emergency regulations implementing
38 this section and the readoption of emergency regulations authorized
39 by this subdivision shall be deemed an emergency and necessary
40 for the immediate preservation of the public peace, health, safety,

1 or general welfare. The initial emergency regulations and the
2 readoption of emergency regulations authorized by this section
3 shall be submitted to the Office of Administrative Law for filing
4 with the Secretary of State and each shall remain in effect for no
5 more than 180 days, by which time final regulations may be
6 adopted.

7 (3) The commissioner shall consult with the Director of the
8 Department of Managed Health Care to ensure consistency and
9 uniformity in the development of regulations under this
10 subdivision.

11 (4) This subdivision shall become inoperative on March 1, 2016.

12 (q) Nothing in this section shall impose on health insurance
13 policies the cost sharing or network limitations of the plans
14 identified in subdivision (a) except to the extent otherwise required
15 to comply with provisions of this code, including this section, and
16 as otherwise applicable to all health insurance policies offered to
17 individuals and small groups.

18 (r) For purposes of this section, the following definitions shall
19 apply:

20 (1) “Exchange” means the California Health Benefit Exchange
21 created by Section 100500 of the Government Code.

22 (2) “Habilitative services” means medically necessary health
23 care services and health care devices that assist an individual in
24 partially or fully acquiring or improving skills and functioning and
25 that are necessary to address a health condition, to the maximum
26 extent practical. These services address the skills and abilities
27 needed for functioning in interaction with an individual’s
28 environment. Examples of health care services that are not
29 habilitative services include, but are not limited to, respite care,
30 day care, recreational care, residential treatment, social services,
31 custodial care, or education services of any kind, including, but
32 not limited to, vocational training. Habilitative services shall be
33 covered under the same terms and conditions applied to
34 rehabilitative services under the policy.

35 (3) (A) “Health benefits,” unless otherwise required to be
36 defined pursuant to federal rules, regulations, or guidance issued
37 pursuant to Section 1302(b) of PPACA, means health care items
38 or services for the diagnosis, cure, mitigation, treatment, or
39 prevention of illness, injury, disease, or a health condition,
40 including a behavioral health condition.

(B) “Health benefits” does not mean any cost-sharing requirements such as copayments, coinsurance, or deductibles.

(4) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(5) “Small group health insurance policy” means a group health care service insurance policy issued to a small employer, as defined in Section 10753.

SEC. 7. Section 10112.35 is added to the Insurance Code, to read:

10112.35. A specialized health insurance policy described in Section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. Sec. 18031(d)(2)(B)(ii)) that provides pediatric oral care benefits through the Exchange shall be subject to Section 10133.5 and Article 4.5 (commencing with Section 10181.1).

SEC. 8. Section 10181.2 of the Insurance Code is amended to read:

10181.2. This article shall apply to health insurance policies offered in the individual or group market in California. However, this article shall not apply to a specialized health insurance policy, other than one providing pediatric oral care benefits through the Exchange, as described in Section 10112.35; a Medicare supplement policy subject to Article 6 (commencing with Section 10192.05); a health insurance policy offered in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code); a health insurance policy offered in the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5)); a health insurance conversion policy offered pursuant to Section 12682.1; or a health insurance policy offered to a federally eligible defined individual under Chapter 9.5 (commencing with Section 10900).

SEC. 9. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because

1 *the only costs that may be incurred by a local agency or school*
2 *district will be incurred because this act creates a new crime or*
3 *infraction, eliminates a crime or infraction, or changes the penalty*
4 *for a crime or infraction, within the meaning of Section 17556 of*
5 *the Government Code, or changes the definition of a crime within*
6 *the meaning of Section 6 of Article XIII B of the California*
7 *Constitution.*

8 ~~SEC. 3.~~

9 *SEC. 10.* This act is an urgency statute necessary for the
10 immediate preservation of the public peace, health, or safety within
11 the meaning of Article IV of the Constitution and shall go into
12 immediate effect. The facts constituting the necessity are:

13 In order to update state law consistent with federal requirements
14 at the earliest possible time, it is necessary that this bill take effect
15 immediately.